Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 02/26/01?

   b. The request was received on 02/26/02.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC 60 and Letter Requesting Dispute Resolution 03/22/02
   b. HCFA-1450s
   c. EOBs
   d. Reimbursement data (EOBs and reimbursement log)
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 04/12/02
   b. HCFA-1450s
   c. Audit summaries/EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 03/27/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 03/29/02. The response from the insurance carrier was received in the Division on 04/12/02. Based on 133.307 (i) the insurance carrier's response is timely

4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 03/22/02,
"Texas Administrative Code Section 133.304 specifically provides 'the explanation of benefits **shall include the correct payment exception codes** required by the Commission's instructions.'…The EOB provided by the Carrier, only refers to '1' as a reason for reduction of payment for some of the billed charges and the remainder of the billed charges do not have any type of reference as to the reduction of payment, the form of payment exception codes."

2. Respondent: Letter dated 04/12/02,
"Respondent argues that the TWCC-60, as submitted by the Requestor, simply does not contain sufficient justification to warrant further reimbursement. Respondent maintains that if the Requestor feels the amount Respondent reimbursed to be inadequate, then Requestor must show specific reasons for such inadequacy."

IV. FINDINGS

1. Based on Commission Rule 133.307(d)(1&2), the only date of service eligible for review is 02/26/01.

2. The provider billed a total of $15,947.70 on the date of service in dispute.

3. The carrier reimbursed a total of $9,056.32. The EOB does not contain a denial code.

4. The amount in dispute per the TWCC-60 is $6,837.38. The difference between the billed amount and the amount reimbursed is $6,891.38.

5. The provider's Reconsideration Request letter dated 09/27/01 states, "…charges are fair and reasonable, and we expect payment at 100% of those billed charges." This letter provides the issue of this dispute, which is fair and reasonable reimbursement.

V. RATIONALE

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

Section 413.011 (d) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The carrier's response does not contain a methodology to meet the requirements of Commission Rule 133.304 (i)(1-4). The provider has submitted reimbursement data in an effort to document what they consider fair and reasonable reimbursement. The provider has submitted 6 EOBs from other carriers. These EOBs have billed amounts ranging from $3,430.19 (low) to $18,734.32 (high). The percentage amount of reimbursement paid on these EOBs is from 30.8% to 90.0%. In addition, the provider has submitted a reimbursement log of other EOBs. This list shows the date of service, the amount billed, amount reimbursed, percentage of the billed amount reimbursed, and the payer of the bill. The list shows a wide range in the amount billed and in the amount of reimbursement received as a percentage. The list contains no references to the treatments/services performed.

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine, based on the information provided by the parties, what represents fair and reasonable reimbursement. Although the carrier does not present a methodology, the provider did receive reimbursement of 56.8% of the billed amount. The provider's documentation indicates that reimbursement rates as low as 30.8% or as high as 90% could be considered fair and reasonable. The provider has not submitted sufficient documentation to show that the amount of reimbursement requested is fair and reasonable or that the amount of reimbursement received is not fair and reasonable. Therefore, no additional reimbursement is recommended.

The above Findings and Decision are hereby issued this 13th day of May 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division